AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____
Last First M.I. **SSN:** _____

I authorize:

❑ Hunt Regional Healthcare (903−408−1856)
(includes all affiliated locations)

❑ Other: _____

To release to: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

This information is needed for the purpose of:

❑ At the request of the individual ❑ Litigation
❑ Medical Care ❑ Insurance ❑ Other: _____

Date information is needed: _____

Information to be sent via:

❑ Patient to pick up records ❑ Send by Mail ❑ Fax to: _____
❑ Electronically Please provide email address: _____

TREATMENT DATES TO BE INCLUDED: _____ to _____

Please check all applicable information requested:

❑ Demographics Sheet
❑ History and Physical
❑ Discharge Summary
❑ Operative Reports
❑ Pathology Reports
❑ ER Records
❑ Consultation Reports
❑ MD Progress Notes
❑ Physicians Orders
❑ Nursing Notes
❑ EKG/Cardiographics
❑ Laboratory Reports
❑ Medication Records
❑ Diagnostic Imaging Reports
❑ Billing Records
❑ Other (please specify)
_____

I understand that the information to be released may include information regarding a medical condition, which is protected by Federal Law. Unless you indicate otherwise, this information will not be released (if present) to the organization, agency or individual named on this request.

I (patient name)_____ authorize the release of information regarding:

❑ Drug Abuse/Dependence
❑ Alcohol Abuse/Dependence
❑ HIV Test Results
❑ HIV/AIDS/ARC Infection
❑ Psychiatric Conditions

I request and authorize the above named health care provider to release the information specified to the organization, agency or individual named on this request. This authorization is subject to revocation in writing at any time except to the extent that action has been taken and expires **180 days** from the date signed. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. The facility to whom this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of information as authorized above. I understand that the information that is being released is subject to re−disclosure by the recipient and is no longer protected.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Authorized Party **Date**

❑ **Durable Power of Attorney**

❑ **Legal Guardian**

❑ **Other:** _____

If the patient is unable to sign or is a minor, complete the following:

Minor of _____ age

Unable to sign because:

_____

_____
Signature of Witness **Date**